MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address OXYMED, Inc. 3820 W. Northwest Hwy., Ste., 215 Dallas, TX 75220	MDR Tracking No.: M4-04-1253-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas ISD Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.: 02 001826

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
06/10/03	**06/10/03**	**E0236, E1399**	**$394.74**	**$394.74**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in part, "…We have resubmitted this claim with all the necessary documents to process this claim including a signed letter of Medical Necessity and a signed prescription from the patient's treating doctor. TWCC rule guidelines 134.600 clearly states we are to be reimbursed at the estimated cost, which is the full-billed amount…"

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent states in part, "…the Requestor bears the burden of proof to demonstrate the fairness of its charges. The Requestor must show that the amount request is fair and reasonable, not usual or customary or what fees they charge. The Requestor has failed to meet its burden. The Requestor's Additional Information does not contain proper justification for billed costs…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E0236 for date of service 06/10/03 denied as "M". Per Rule 133.1(a)(8) the requestor has met their burden of proof with the submission of redacted EOBs showing the amount they billed and amount they are reimbursed as their fair and reasonable amount. Therefore, additional reimbursement in the amount of $379.74 is recommended.

- HCPCS Code E1399 for date of service 06/10/03 denied as "M". Per Rule 133.1(a)(8) the requestor has met their burden of proof with the submission of redacted EOBs showing the amount they billed and amount they are reimbursed as their fair and reasonable amount. Therefore, additional reimbursement in the amount of $45.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
6/10/2003	E0236	$349.74	$349.74				
6/10/2003	E1399	$45.00	$45.00				
					Total Left Column:		$394.74
					Total Amount Due:		$394.74

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $394.74. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster	01-28-05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____